

**FIRST TIME JUVENILE OFFENDER PROGRAM
SERVICE PLAN/PROGRAM REFERRAL**

REFERRAL TYPE

☐ DA PRESCREEN
☐ PROBATION ☐ CD ☐ DPA
FROM: _____ TO: _____

JUVENILE ID # 03 REFERRAL # _____ PROBATION FILE # 04

NAME: _____ S _____ R _____ DOB _____
LAST FIRST MI

☐ LIMITED ENGLISH PROFICIENCY PRIMARY LANGUAGE _____

ADDRESS: _____ CELL PHONE: _____

CITY _____ STATE WI ZIP: _____ HOME PHONE: _____

LIVES WITH: _____ RELATIONSHIP: _____
NAME

☐ LIMITED ENGLISH PROFICIENCY PRIMARY LANGUAGE _____

FAMILY INFORMATION

☐ M NAME _____ DOB _____ HM PHONE _____

ADDRESS _____ CELL PHONE _____

☐ LIMITED ENGLISH PROFICIENCY PRIMARY LANGUAGE _____

☐ F NAME _____ DOB _____ HM PHONE _____

ADDRESS _____ CELL PHONE _____

☐ LIMITED ENGLISH PROFICIENCY PRIMARY LANGUAGE _____

SIBLINGS: NM _____ DOB _____ NM _____ DOB _____

SIBLINGS INVOLVED AT JJC? ☐ YES ☐ NO IS/PO W/PHONE _____

BMCW INVOLVEMENT? ☐ YES ☐ NO BMCW WKR W/PHONE: _____

GENERAL INFORMATION

SCHOOL: _____ PRIOR SCHOOL: _____ GRADE LEVEL: _____

☐ NOT ATTENDING ☐ NOT ENROLLED PARENTS TO PROVIDE SCHOOL REPORT: ☐ YES ☐ NO

SPECIAL ED: ☐ LD ☐ ED ☐ CD CURRENT GPA: _____ REPORT CARD DATE: _____

RECREATIONAL ACTIVITIES _____

CURRENTLY ON MEDICATION? ☐ YES ☐ NO IF YES, WHAT? _____

PURPOSE OF MEDICATIONS? _____

EMPLOYED? ☐ YES ☐ NO WHERE? _____

ALLEGED OFFENSE _____ VICTIM _____

TRACKER INFORMATION

AGENCY _____ TRACKER _____

TELEPHONE _____ FAX _____

STAFFING DATE _____ PROGRAM START _____ PROGRAM END _____

DPA REQUIREMENTS (THESE MAKEUP THE MANDATORY PROGRAM REQUIREMENTS)

NO CONTACT WITH: ☐ VICTIM(S) _____ ☐ ACCOMPLICE(S) _____

CNSLG/ANGER MNGT/5 STEP ☐ YES ☐ NO

AODA SERVICES ☐ YES ☐ NO AODA ASSESSMENT DATE: _____

RESTITUTION ☐ YES ☐ NO AMOUNT DUE: \$ _____ PAYMENT PLAN? ☐ YES ☐ NO

LETTER OF APOLOGY ☐ YES ☐ NO ☐ COMPLETED - ADDRESSED TO: _____

COMMUNITY SERVICE ☐ YES ☐ NO # HOURS: _____

COMMUNITY EDUCATION ☐ MITCHELL PARK ☐ COOPER PARK DATE _____

SERVICE PLAN

YOUTH'S NAME _____

PROVIDE RELEVANT INFORMATION ABOUT THE YOUTH/FAMILY WHICH WILL PROVIDE ASSISTANCE IN CREATING A SERVICE PLAN. INCLUDE GOALS / STRENGTHS / NEEDS OF YOUTH AND FAMILY / SCHOOL PERFORMANCE :

MY SOCIAL SERVICE PLAN FOR THIS YOUTH AND FAMILY IS: (LIST NETWORK SERVICES YOU ARE RECOMMENDING ALONG WITH THE GOAL FOR EACH SERVICE. INCLUDE WHAT SERVICES YOUTH NEEDS TO AVOID RE-OFFENDING.)

CURRENT SERVICES IN PLACE: _____

<u>NETWORK SERVICES</u>	RECOMMENDED	AUTHORIZED	
INDICATE MANDATORY SERVICES (MAN)	SERVICES (<input type="checkbox"/>)	UNITS	COMMENTS
TRACKING (YTK) (LEVEL _____)	_____	_____	_____
ACADEMIC SUPPORT SERVICES (YAS)	_____	_____	_____
PARENT EDUCATION/TRAINING (YPE)	_____	_____	_____
MENTORING (YMT)	_____	_____	_____
YOUTH/FAMILY COUNSELING (YYN)	_____	_____	_____
YOUTH/FAMILY CLINICAL SERVICES (YYC)	_____	_____	_____
ANGER MANAGEMENT (YAM)	_____	_____	_____
AODA EDUCATION (YEA)	_____	_____	_____
AODA ASSESSMENT (ZXA)	_____	_____	_____
AODA TREATMENT GROUP (ZXG)	_____	_____	_____
AODA TREATMENT INDIVIDUAL (YAT)	_____	_____	_____
RECREATION/LEISURE LVL I (YLR)	_____	_____	_____
LIFE SKILLS/TRAINING(YLS)	_____	_____	_____
_____ I.S./P.O.	_____ DATE	_____ FTJOP SUPERVISOR	_____ DATE